



MDS 3.0 Corrections



December 2013 



Why Accuracy

- The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:
 - — the development of an individualized care plan;
 - — the Medicare Prospective Payment System
 - — Medicaid reimbursement programs
 - — quality monitoring activities, such as the quality measure reports
 - — the data-driven survey and certification process
 - — the quality measures used for public reporting
 - — research and policy development





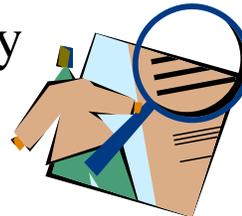
Why Accuracy



- Omnibus Budget Reconciliation Act 1987
- CFR 483.20 (g) (Nursing Home)
 - The assessment must accurately reflect the resident's status
- CFR 483.20 (Swing-bed)
 - The assessment must accurately reflect the resident's status



Discovery



- After reviewing various reports, old assessments, records, etc., you have determined that coding errors exist and you need/or are required to correct the error.....
- Lets begin...What do we do.....



Submitted and **not** accepted by ASAP



- Was the assessment or tracking form submitted & accepted by CMS Quality Improvement and Evaluation Service (QIES) Assessment Submission and Processing (ASAP)?

- No



Edit phase



- Facilities have **up to 7 days to encode (enter into the software) and edit** an MDS assessment after the MDS has been completed.
- Changes may be made to the electronic record for any item during the encoding and editing period, **provided the response refers to the same observation period.**





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Edit phase



- To make revisions to the paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry.
- This procedure is similar to how an entry in the medical record is corrected.



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Edit phase



- When the data are encoded into the provider's MDS system from paper, **the provider is responsible for verifying that all responses in the computer file match the responses on the paper form.**
- **Any discrepancies must be corrected in the computer file during the 7-day encoding period.**





Facility level (internal)

- Correct assessment in facility database based on your software program

When not received by ASAP, Section A0050 will only reflect 1 (add new record)



Facility level (internal)

- If appropriate, contact your software vendor when correcting (edit) internally.
- Make sure you tell vendor that you **did not** transmit the record.
- Correct internally (edit) and transmit with next batch.



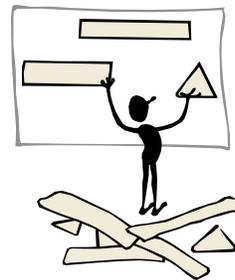
Received by ASAP-Yes

- Modify
- Inactivate



Modify when accepted by ASAP

- Record received by ASAP and is a valid record, **but**
 - Has errors... **SO**
 - Need to Correct (Modify)
 - For Example





Modify (Accepted by ASAP)

- A Modification Request is used to modify most MDS items, including:
- Target Date
 - Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1)
 - Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12)



Modify (Accepted by ASAP)

- Assessment Reference Date (ARD, Item A2300) on an OBRA or PPS assessment.*
- Type of Assessment (Item A0310)**
- Clinical Items (Items B0100-V0200C)





Modify (Example)

- ***Note: The ARD (Item A2300) can be changed** when the ARD on the assessment represents a data entry/typographical error. However, the **ARD cannot be altered if it results in a change in the look back period and alters the actual assessment timeframe.**



Modify (Accepted by ASAP)

- ****Note: The Type of Assessment items (Item A0310) can only be modified when the Item Set Code (ISC) of that assessment does not change.** In other words, if the Item Subset (full list can be found in Chapter 2, Section 2.5) would change, the modification cannot be done.
- Also note reference table on pages 2-77 & 78 for ISC's.



Modify (Example) 1



■ Modification allowed

- An Admission assessment (ISC = NC) was completed and accepted into the ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC). The modification process could be used in this case as the ISC would not change.



Modify (Example) 2, Not allowed

■ Modification not allowed.

- A stand-alone Discharge assessment (ISC = ND) was completed and accepted into the ASAP system. The provider later (that is, after the day of discharge) determined that the assessment should have been a 30-day PPS assessment combined with a Discharge assessment (ISC = NP).



Modify (Example) 2

- This modification would **not** be allowed as the ISC for the Discharge assessment combined with the 30-day PPS is different than the stand-alone Discharge ISC. This is an example of a missing 30-day assessment.
- Key words = Item Set Code (ISC)



Modify

- Contact software vendor on how to retrieve the already transmitted and accepted record so you can **MODIFY**
 - Determine with vendor how the completion of Section X will be handled as related to prior record information





Time Saver



■ Ensure that the following items are completed **accurately** or you will create more work for yourself.

- A0050
 - X0150
 - X0200
 - X0300
 - X0400
- X0500
 - X0600
 - X0700
 - X0800

■ Let's take a closer look.




Section A, Review of Form

Section A		Identification Information
A0050. Type of Record		
Enter Code	<ol style="list-style-type: none"> 1. Add new record → Continue to A0100, Facility Provider Numbers 2. Modify existing record → Continue to A0100, Facility Provider Numbers 3. Inactivate existing record → Skip to X0150, Type of Provider 	



1. Add new record
2. Modify existing record
3. Inactivate existing record




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Section X, Review of Form

X0150. Type of Provider	
Enter Code	Type of provider
<input type="checkbox"/>	1. Nursing home (SNF/NF)
	2. Swing Bed

Identifies Prior Record ↓

X0200. Name of Resident on existing record to be modified/inactivated	
X0200. Name of Resident on existing record to be modified/inactivated	
A. First name:	<input type="text"/>
C. Last name:	<input type="text"/>




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Section X, Review of Form

X0300. Gender on existing record to be modified/inactivated	
Enter Code	1. Male
<input type="checkbox"/>	2. Female

Identifies Prior Record ↔

X0400. Birth Date on existing record to be modified/inactivated					
<input type="text" value="01"/>	-	<input type="text" value="02"/>	-	<input type="text" value="19"/>	<input type="text" value="18"/>
Month		Day		Year	





Section X, Review of Form

X0500. Social Security Number on existing record to be modified/inactivated

X0500. Social Security Number on existing record to be modified/inactivated

				-			-				
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Identifies Prior Record



X0600. Type of Assessment on existing record to be modified/inactivated

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code	A. Federal OBRA Reason for Assessment
<input type="text"/>	01. Admission assessment (required by day 14)
<input type="text"/>	02. Quarterly review assessment
	03. Annual assessment

Includes X0600 A, B, C, D & F



Section X, Review of Form

X0700. Date on existing record to be modified/inactivated - **Complete one only**

X0700. Date on existing record to be modified/inactivated - Complete one only

A. Assessment Reference Date - Complete only if X0600F = 99

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year		

B. Discharge Date - Complete only if X0600F = 10, 11, or 12

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year		

C. Entry Date - Complete only if X0600F = 01

<input type="text"/>	-	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year		

Identifies
Prior
Record

X0800. Correction Number

Enter the number of correction requests to modify/inactivate the existing record, including the present one

Enter Number	<input type="text"/>	<input type="text"/>
	0	1

Enter Number

<input type="text"/>	<input type="text"/>
0	1

Number of times record modified



Section X, Review of Form

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)

↓ Check all that apply

<input type="checkbox"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	E. End of Therapy - Resumption (EOT-R) date
<input type="checkbox"/>	Z. Other error requiring modification
	If "Other" checked, please specify: _____



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X0900 Defined



- (a) Transcription Error
 - (e.g. Weight is 119 and entered as 191) (copied wrong from other source)
- (b) Data Entry Error
 - (e.g. individual therapy minutes entered as 3000 minutes when minutes should have been 300)



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X0900 Defined



- (c) Software Product Error
 - (e.g. software stored weight as 20 rather than 200)
- (d) Item Coding Error
 - (e.g. coding a 4 in ADL's self performance when it should have been a 2)
- (z) Other error
 - If other please specify



RN Attestation

X1100. RN Assessment Coordinator Attestation of Completion	
A. Attesting individual's first name:	<input type="text"/>
B. Attesting individual's last name:	<input type="text"/>
C. Attesting individual's title:	<input type="text"/>
D. Signature	<input type="text"/>
E. Attestation date	<input type="text"/> - <input type="text"/> - <input type="text"/>
	Month Day Year

Must be an RN (RAI, Pg. X-10 thru X-11)





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Modify

- Correct the items on the record and transmit as a Modification.
- Your software vendor will have to explain how you add this corrected record to your next batch for transmission.



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Where did it go ?

- Corrected record replaces the erroneous record in the database and becomes the current version.
- Erroneous record is placed in CMS' "history" file.



What to Save



- Old Assessment or Tracking
- New Corrected Assessment or Tracking including Section X
- Documentation in chart



Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

- The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy).





Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum,



Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

- Hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.
- Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants),





Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

- State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident.



Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

- Nursing homes that do not have the capability of maintaining the MDS electronically must adhere to the current requirement that either a hand written **or a computer-generated copy be maintained in the clinical record. Either is equally acceptable. This includes all MDS (including Quarterly) assessments and CAA(s) summary data completed during the previous 15-month period.**





Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

- Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder).
- Additional detail RAI pages 2-5 to 2-7

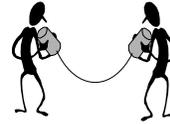


Why Save MODIFICATION

- Provide continuity of care as related to care planning
 - Document the date you discovered the error
 - Correction must be completed (X1100E) within 14 days from identifying the error (RAI, pg. 5-10)
- Trail for auditor to verify Modification was completed



Be Aware



- Modification will only correct information on that specific record
- Does not fix other assessments with the same problem
- May have to modify all prior records with same issue



Inactivate (Accepted by QIES ASAP)

- An Inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge.
- An Inactivation (Item A0050 = 3) **must be completed when any of the following items are inaccurate:**



Inactivation Requests

- Type of Provider (Item A0200)
- Type of Assessment (A0310) **when the Item Subset would change had the MDS been modified**
- Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1) **when the look-back period and/or clinical assessment would change had the MDS been modified**



Inactivation Requests

- Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment **when the look-back period and/or clinical assessment would change had the MDS been modified**





Inactivation Requests

- Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid.
- In such instances a new ARD date must be established based on MDS requirements, which is the **date the error is determined or later, but not earlier.**



Inactivation Requests

- The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS assessment completion requirements.



Inactivation

Section A	Identification Information
A0050. Type of Record	
Enter Code	
<input type="text" value="3"/>	
	1. Add new record → Continue to A0100, Facility Provider Numbers
	2. Modify existing record → Continue to A0100, Facility Provider Numbers
	3. Inactivate existing record → Skip to X0150, Type of Provider



Inactivation



- Complete **all prior record identifiable** information for record to be inactivated
- Identical to modification slides
 - X0200 through X0800
 - ❖ Software may automatically fill these for you based on their program
 - ❖ If not be careful completing to save time





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X1050



X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)

↓ Check all that apply

<input type="checkbox"/>	A. Event did not occur
<input type="checkbox"/>	Z. Other error requiring inactivation
If "Other" checked, please specify: <input type="text"/>	





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Inactivate



- If appropriate, contact software vendor on how to retrieve the already transmitted and accepted record so you can Inactivate
 - ❖ Generally termed archived record, locked, or “doing the attestation”
- Determine from vendor how the completion of Section X will be handled (similar/same as modification related to prior record detail)



Be Aware



- After inactivation is processed, there is no remaining active version of that record.
- After inactivation, all versions of that record are stored and moved to the facility history file so that it will not be used for reporting purposes.



Correction Time Frames---Reminder



- Completion is within 14 days of error detection
 - X1100E (date discovered + 14 days = completion date)
- Submission, follow time frames RAI, pg. 5-3 & 5-4



New Error Messages



- **-1061** **Warning:** A change in the target date and/or RFA in combination with a change in the clinical item listed may indicate improper coding. Other clinical items may also have changed.



New Error Messages



- **-1062** **Warning:** A change in the target date and/or RFA in combination with a change in the clinical item listed and Medicare RUG may indicate improper coding. Other clinical items may also have changed.



New Error Messages

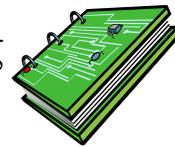


- **-3839 Fatal:** Non-matching ISC: The ISC of the modification record does not match the ISC of the record to be modified.



Manual Correction Request Form

Required for the following



- Submission requirement SUB_REQ (A0410)
- Wrong Facility ID
- Test record(s) sent as production (rare)
 - CMS says test records will be rejected effective 9-15-2013
- More Next 2 slides





Be Careful **CAUTION**

- Do not submit PPS assessments for residents who qualify for a Medicare Part A stay when the payer is private insurance, HMO, Medicare Advantage, etc. If you have mistakenly transmitted one of these as a PPS assessment, please Delete the record –
- Submit PPS assessments for Medicare Part A Stay where Medicare is the Payer.



Be Careful **CAUTION**

- Nursing homes are required to submit **Omnibus Budget Reconciliation Act required (OBRA) MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source.**
- Skilled nursing facilities (SNFs) and hospitals with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS).





Be Careful

- **Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans.**



Form details

- **The Manual Correction Form** must be obtained from QIES and we will verify what has transpired and fax or e-mail the form to you for completion.
- The **facility** must submit the completed form to the State Agency via **certified mail** through the United States Postal Service (USPS).
- The State Agency must approve the provider's request and submit a signed form to the National QIES Help Desk via **certified mail** through the USPS.





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Questions



- Refer to the separate Q&A handout for solutions.



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Scenario

- A facility submits a record and later modifies it. Then the facility discovers that the earlier record was correct after all. The later (active) version of the record is in error.

- What do you do?



Scenario

- A facility completed a Discharge Assessment on a resident. Later, they discovered they submitted the discharge on the wrong resident.

- What do you do?



Scenario

- A facility discovers a valid MDS assessment contains many miscoded items for all the interview sections and the ADL's on the admission assessment that was transmitted and accepted in the database.

- What do you do?





Scenario



- When entering the assessment into the facility's software, the ARD, intended to be 10/12/2013, was inadvertently entered as 10/02/2013.
- The interdisciplinary team (IDT) completed the assessment based on the ARD of 10/12/2013 (that is, the seven day look back was 10/06/2012 through 10/12/2013).
- What do you do?



Scenario



- An Admission assessment (ISC = NC) was completed and accepted into the ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC).
- What do you do?



Modification vs. Significant Correction vs. Significant Change in Status



So



- When do we do a Modification?
- When do we do a Significant Correction?
- When do we do a Significant Change in Status Assessment?
- Let's review a few definitions and concepts that relate to significant errors and corrections.





Modification Defined



- A type of correction allowed under the MDS Correction Policy. A modification is required when a valid MDS record has been accepted by the CMS MDS database, but the information in the record contains errors. The modification will correct the record in the CMS database. A modification is not done when a record has been rejected.



Significant Error



- A “**significant error**” is an error in an assessment where:
 - The resident’s overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
 - The error has not been corrected via submission of a more recent assessment.
- *A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident’s health status.*



Significant Error



- Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered significant errors.



Minor Error



- All other errors related to the coding of MDS items are considered minor errors.



What are the rules?



- SNF/PPS only
- Received by ASAP



PPS



- If the assessment was performed for **Medicare purposes only** (A0310A = 99 and A0310B = 01 through 07) **or for a discharge** (A0310A = 99 and A0310F = 10 or 11), **no Significant Change in Status Assessment or Significant Correction to Prior Assessment is required.** The provider would determine if the Medicare-required or Discharge assessment should be modified or inactivated.





Significant Correction to Prior Comprehensive Assessment (SCPA)



- The SCPA is a comprehensive assessment for an existing resident that must be completed when the Interdisciplinary team (IDT) determines that a resident's prior comprehensive assessment contains a significant error.



Significant Correction to Prior Comprehensive Assessment (SCPA)



- A0310A = 05
- A SCPA is appropriate when:
 - the erroneous comprehensive assessment has been completed and transmitted/submitted into the MDS system; and
 - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.



Significant Correction to Prior Comprehensive Assessment (SCPA)



- Nursing homes should document the initial identification of a significant error in an assessment in the progress notes.
- The ARD **must** be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days).



Significant Correction to Prior Quarterly (SCQA)

- The SCQA is an OBRA non-comprehensive assessment that must be completed when the IDT determines that a resident's prior Quarterly assessment contains a significant error.



Significant Correction to Prior Quarterly (SCQA)



- A0310 = A6
- A SCQA is appropriate when:
 - the erroneous Quarterly assessment has been completed (MDS completion date, Item Z0500B) and transmitted/submitted into the MDS system; and
 - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.



Significant Correction to Prior Quarterly (SCQA)

- Nursing homes should document the initial identification of a significant error in an assessment in the progress notes.
- The ARD must be within 14 days after the determination that a significant error in the prior Quarterly assessment has occurred (determination date + 14 calendar days) and no later than 14 days after determining that the significant error occurred. (RAI, 2-32)





Summary



- When doing significant corrections, you will be doing in today's timeframe (ARD).
 - ❖ Addressed on prior slide. (RAI 2-32)
- The OBRA clock will reset based on significant corrections.
- Always Modify (automated process) the erroneous assessment along with completing the significant correction **when applicable**.



Summary



- SCPA and SCQA is Not required if another assessment has **been completed that addressed the significant error** for quarterly or comprehensive assessments (Modification only Required).
- SCPA and SCQA are not required for errors made for a PPS only assessment.



A2200 Completion

A2200. Previous Assessment Reference Date for Significant Correction		
Complete only if A0310A = 05 or 06 ←		
<input type="text"/>	-	<input type="text"/>
<input type="text"/>	-	<input type="text"/>
<input type="text"/>	-	<input type="text"/>
<input type="text"/>	-	<input type="text"/>
Month	Day	Year

This section will require completion and is only used for significant corrections



SCSA



- A0310A = 4
- A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS.
- If a significant change in status assessment (SCSA) is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.



Remember



- Always modify the erroneous record when accepted in ASAP.
- If a significant error is identified, then a new Assessment Reference Date for the Significant Correction (current time) is required.
- Since error, no other assessment has addressed the significant error, then the Significant Correction is required.



- Clinical Q&A's
- Refer to the separate Q&A handout for solutions.





Scenario 1



- The facility discovers that a valid OBRA assessment contains inaccurate information.
- The assessment has been transmitted and accepted into the ASAP database.
- No other assessment has been performed since error occurred.



Scenario 1 continued



- The Interdisciplinary team reviewed the resident's record and determined the prior assessment errors were Significant errors.
- On further review, the team found significant changes also occurred with the resident's condition since the last assessment.
- The assessment has been transmitted and accepted into the ASAP database.
- **What do I do?**



Scenario 2



- The facility discovers that a valid OBRA assessment contains inaccurate information.
- The assessment has been transmitted and accepted into the ASAP database.
- There has been no other assessment performed since this one.
- The interdisciplinary team reviewed the resident's record and determined the assessment errors were not Significant errors.
- **What do I do?**



Scenario 3



- Three errors found in Ms. T's First Assessment; A0310A = 99; A0310B = 1.
 - Incorrect SS#
 - Incorrect Gender
 - M0300C = 0 (# of stage 3 pressure ulcers) when it should have been 2.



Scenario 3 continued



- No other assessment has been completed.
- The assessment is valid and has been accepted by the ASAP.

- **What do I do?**



Scenario 4



- Three errors found in Mr. T's Assessment;
- A0310A = 1; and A0310B = 1.
 - Incorrect SS#, Incorrect Gender &
 - M0300C = 0 (# of stage 3 pressure ulcers) when it should have been 2.
 - The assessment is valid and has been accepted by the ASAP database.



Scenario 4 continued



- No other assessment has been completed since this error.
- The interdisciplinary team determined this was a significant error but no significant change in the resident's condition occurred.
- What do I do?



The End

- Please refer to the Answers section to see how well you did with all questions. If you would like further clarification on any of the Q&As, or for any additional questions, please call us at:

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